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Eradicating Elder Abuse in California Nursing Homes

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ERADICATING ELDER ABUSE IN CALIFORNIA NURSING HOMES

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INTRODUCTION

For weeks, three certified nursing assistants (CNAs) at a California nursing home physically assaulted and sexually battered a paralyzed seventy-eight-year-old man dependent on nursing staff for bathing and toileting.[1] They pinched his nipples and penis, twisted the skin on his arms, and forced him to eat feces from his adult briefs.[2] Another patient at the same facility, with mental retardation and cerebral palsy, was often given cold showers and hit on the head with soap bottles before being paraded back to his room naked and soaking wet.[3] The three CNAs took videos of this conduct, and even showed fellow nursing home staff; but no one reported it until after the damage was done.[4] This conduct is atrocious, inhumane, and criminal, yet the abuse at this facility went on for months and affected five male nursing home residents.[5] None of the CNAs involved in the abuse were ever criminally prosecuted.[6] Egregious conduct like this captures headlines, seizes the nation's attention, and horrifies America.[7] However, most cases of elder abuse and neglect proceed undetected by society.[8] Victims often suffer in silence, perhaps dealing with painful bedsores from sitting in

1. PAMELA LEW ET AL., DISABILITY RIGHTS CALIFORNIA, VICTIMIZED TWICE: ABUSE OF NURSING HOME RESIDENTS, NO CRIMINAL ACCOUNTABILITY FOR PERPETRATORS 7 (2010), *available at* http://www.disabilityrightsca.org/pubs/548801.pdf.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.* at 24.

7. Christine V. Williams, Comment, *The Nursing Home Dilemma in America Today: The Suffering Must be Recognized and Eradicated*, 41 SANTA CLARA L. REV. 867, 867 (2001).

8. *See id.*

their own excrements for hours on end.[9]

Nursing homes are "an indelible part of our health care landscape."[10] Over forty percent of Americans will use a nursing home in their lifetime[11] and—with seventy-seven million baby boomers retiring early in this century[12]—that figure is only expected to grow. In 2007, there were 1197 nursing homes in California alone, the equivalent of 115,158 beds.[13] Despite extensive regulatory efforts, nursing homes perpetually promote a cycle of abuse and subsequently endanger a significant portion of the population.

Several factors contribute to this horrifying situation. First, studies show that stressful working conditions of nursing homes—including understaffing, long hours, and working with difficult residents—may trigger abuse by nursing home staff.[14] Second, many nursing home residents have cognitive impairments that interfere with their abilities to recognize and report abuse.[15] Third, the private nature of nursing homes insulates abuse from public view and, in effect, eliminates any real accountability.[16] These features, combined with our nation's growing elderly population, raise grave concerns about treatment of the elderly.

Nationally, elder abuse and neglect causes serious harm to between 500,000 and five million individuals each year.[17] In California alone, there are over 132,000 elders abused each year.[18] The numbers may be even higher: for every instance

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9. *Id.*

10. LEW ET AL., *supra* note 1, at 1.

11. *Id.*

12. Williams, *supra* note 7, at 868.

13. LEW ET AL., *supra* note 1, at 15.

14. *See* Mary C. Sengstock et al., *Identification of Elder Abuse in Institutional Settings: Required Changes in Existing Protocols*, 2 J. ELDER ABUSE & NEGLECT 31, 45 (1990).

15. *Elder Justice: Protecting Seniors from Abuse and Neglect: Hearing Before the Comm. on Fin.*, 107th Cong. 8 (2002) (statement of Catherine Hawes, Professor, Texas A & M University).

16. LEW ET AL., *supra* note 1, at 16.

17. *Elder Justice Act, the Elder Abuse Victims Act of 2008, the School Safety Enhancements Act of 2007, and the A Child Is Missing Alert and Recovery Center Act: Hearing on H.R. 1783, H.R. 5352, H.R. 2352 and H.R. 5464 Before the Subcomm. on Crime, Terrorism, and Homeland Sec. of the H. Comm. on the Judiciary*, 110th Cong. 99 (2008) [hereinafter *Hearings*] (statement of Joseph D. O'Connor, Chairman, American Bar Association Commission on Law and Aging).

18. *What You Need to Know About Elder Abuse*, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, http://web.archive.org/web/20100923140512/

of abuse reported, at least five others go unreported.[19] Because of this underreporting, it is difficult to maintain accurate statistics on elder abuse crimes.[20]

Elder abuse encompasses physical abuse, neglect, financial abuse, mental suffering, and isolation, among others.[21] This Comment, however, focuses on physical abuse and neglect in nursing homes, which manifests in the form of physical assault, sexual abuse, threats and harassment, or inadequate maintenance of personal hygiene.[22] The underreporting of these incidents is exacerbated by the fact that a significant number of elders suffer from mental, physical, and verbal impairments that leave them vulnerable to abuse and incapable of asking for help.[23]

This Comment addresses the presence of elder physical abuse and neglect in California nursing homes and proposes necessary action towards eliminating mistreatment of the growing and vulnerable elderly population.[24] Part I depicts

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http://www.canhr.org/abuse/abuse_needtoknow.htm (last visited Dec. 15, 2010). Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California's long term care consumers. *About CANHR*, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM (CANHR), http://www.canhr.org/about/index.html (last visited June 21, 2011). "Through direct advocacy, community education, legislation and litigation, it has been CANHR's goal to educate and support long term care consumers and advocates regarding the rights and remedies under the law, and to create a united voice for long term care reform and humane alternatives to institutionalization." *Id.*

19. *Hearings*, *supra* note 17, at 64 (testimony of Robert Blancato, National Coordinator, Elder Justice Coalition).

20. NAT'L DIST. ATTORNEYS ASS'N, POLICY POSITIONS ON THE PROSECUTION OF ELDER ABUSE, NEGLECT, AND FINANCIAL EXPLOITATION 3 (2003) [hereinafter NDAA POLICY], *available at* http://www.ndaa.org/pdf/NDAA%20Elder%20Abuse%20Policy.pdf.

21. *What is Elder Abuse?*, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, http://web.archive.org/web/20100722083833/http://www.canhr.org/abuse/abuse_whatis.htm (last visited Dec. 15, 2010).

22. JOHN HILL, SUBCOMM. ON AGING AND LONG-TERM CARE, CAL. SENATE RULES COMM., CALIFORNIA'S ELDER ABUSE INVESTIGATORS: OMBUDSMEN SHACKLED BY CONFLICTING LAWS AND DUTIES 11 (2009), *available at* http://www3.senate.ca.gov/deployedfiles/vcm2007/senoversight/docs/ombudsmanreport10_29.pdf.

23. CAL. WELF. & INST. CODE § 15600(c)–(d) (West 2011).

24. This Comment is not meant to address the full extent of the problem of elder abuse or the full range of interventions available to address it. Most notably, this Comment does not discuss financial elder abuse, which also poses a significant threat to the elderly population, and does not address elder abuse that occurs within the confines of one's home.

the landscape of today's nursing homes in California and outlines the parties involved.[25] Part II outlines the issues faced by the involved agencies, analyzes their current approaches, and proposes improvements to the current structure.[26] Part III introduces other possible improvements to the elder abuse system and areas beyond the state agencies.[27] This Comment seeks to enumerate the steps needed to eradicate elder abuse and neglect in California nursing homes by improving the civil and criminal litigation scheme already in place.

I. BACKGROUND

Nursing homes have changed the way elders are cared for. In the past two centuries, nursing homes evolved from poor relief centers to a "highly sophisticated business industry."[28] In the United States, "[a]pproximately 1.6 million people live in approximately 17,000 licensed nursing homes. . . ."[29] These numbers are substantial and California is no exception to this prevalence of individuals occupying nursing homes. Approximately 100,000 Californians reside in nursing homes,[30] with elders comprising a majority of that population.[31]

As the elderly population continues to grow, action and reform are increasingly necessary. California (which defines an "elder" as a person who is sixty-five years of age or older[32]) faces the most dramatic elderly population growth in the future. The United States Census Bureau recently estimated that 4.14 million California residents were over the age of

25. *See infra* Part I.

26. *See infra* Part II.

27. *See infra* Part III.

28. David A. Bohm, *Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care In The Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317, 324 (2001).

29. NDAA POLICY, *supra* note 20, at 3.

30. MICHELLE BAASS, CAL. SENATE OFFICE OF RESEARCH, INSIDE CALIFORNIA'S NURSING HOMES: A PRIMER FOR EVALUATING THE QUALITY OF CARE IN TODAY'S NURSING HOMES 3 (2009), *available at* http://www.sor.govoffice3.com/vertical/Sites/%7B3BDD1595-792B-4D20-8D44-626EF05648C7%7D/uploads/%7B6FACADB8-E1CF-4B8B-A433-868F54712C8D%7D.PDF.

31. NDAA POLICY, *supra* note 20, at 3.

32. WELF. & INST. § 15610.27.

sixty-five and also projected that California's elderly population would double to 6.4 million by 2025, growing faster than in any other state in the country.[33] In fact, "[t]he number of California residents age [eighty-five] and older—those who are most likely to need extended care at home or in nursing homes—is likely to more than double by the year 2030, when the bulk of baby boomers will come of advanced age."[34] Further, Americans are living longer than before. Between 1991 and 2001, the life expectancy jumped from seventy-five to seventy-seven.[35]

Accompanying the growing population of elders, and elders dependent upon nursing homes, is elder abuse. "Elder abuse is a shocking reality to hundreds of nursing home victims throughout California who suffer devastating consequences, sometimes including serious injuries or death."[36] The elderly are prone to risks of abuse, neglect, and abandonment and, therefore, need special attention.[37] The "most common and severe form of abuse in nursing homes is neglect."[38] Residents have died of serious bedsore infections (which became life-threatening due to inadequate care);[39] have become "malnourished or dehydrated for lack of food and water;" and have been "unnecessarily restrained or

33. CHARLENE HARRINGTON & JANIS O'MEARA, CAL. HEALTHCARE FOUND., LONG TERM CARE: FACTS AND FIGURES 3 (2007), *available at* http://www.canhr.org/reports/2007/LTCFactFigures07.pdf; Christine M. Wickers, Das *Closes the Door on Civil Liability for Financial Institution Failure to Make Mandated Elder Abuse Report*, 16:4 CAL. TRUSTS AND ESTATES QUARTERLY, Winter 2010 at 20. The elder population is also growing nationally. The U.S. Census Bureau reported that from 1900 to 1996, the population of elders grew from three million to thirty-four million; from 1990 to 2000, the population over sixty-five-years-old increased by 12%; and from 2000 to 2009, the population over sixty-five-years-old increased by 13% (jumping from 34,992,000 to 39,570,000). *Id.*

34. HARRINGTON & O'MEARA, *supra* note 33 at 4. The California Department of Finance reports a projected 36.4% increase from 2010 to 2020 in people over age sixty; the California State Plan on Aging claims that it will increase by 39%. Wickers, *supra* note 33 at 20.

35. HARRINGTON & O'MEARA, *supra* note 33 at 4.

36. CAL. ADVOCATES FOR NURSING HOME REFORM, NURSING HOME ABUSE AND CALIFORNIA'S BROKEN ENFORCEMENT SYSTEM 1 (2006) [hereinafter BROKEN], *available at* http://www.canhr.org/reports/2006/Abuse_Report_2006_solo.pdf.

37. WELF. & INST. § 15600(b).

38. BROKEN, *supra* note 36, at 3.

39. HILL, *supra* note 22, at 11.

drugged."[40] In 2005, "a partially paralyzed resident developed three bedsores overnight when staff left her sitting on a bedpan for over [ten] hours."[41] Nursing homes must be held accountable for this type of conduct.

The "unabated, tragic levels of abuse in California nursing homes" are a result of the state's broken enforcement system.[42] Victims are repeatedly abused because administrators fail to report the abusive conduct to law enforcement and licensing officials or because the California Department of Health Services efforts are delayed.[43] Between 2005 and 2006, reports indicated that one-fifth of California's nursing facilities did not meet state-mandated staffing requirements and "twice as many of California's 115,000 plus residents [were] placed in physical restraints as [were] nationally."[44] When abuse occurs in a nursing home, staff witnesses become mandated reporters and must notify either the long-term care[45] ombudsman or the local law enforcement agency.[46] The ombudsman or law enforcement agency is then "required to report the incident to the [California] Department of Public Health ([C]DPH), the local district attorney, and the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA)."[47] However, as this Comment will

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40. BROKEN, *supra* note 36, at 3.

41. *Id.*

42. *Id.* at 1.

43. *Id.*

44. *Elder Abuse in Nursing Homes*, BUREAU OF MEDI-CAL FRAUD AND ELDER ABUSE, STATE OF CALIFORNIA DEPARTMENT OF JUSTICE OFFICE OF THE ATTORNEY GENERAL, http://ag.ca.gov/bmfea/elder.php [hereinafter BUREAU] (last visited Dec. 15, 2010).

45. "Long-term care" is a broad term that encompasses most health facilities except general and psychiatric hospitals.

> "Long-term health care facility" means any facility licensed pursuant to Chapter 2 (commencing with section 1250) that is any of the following:
> (1) Skilled nursing facility.
> (2) Intermediate care facility.
> (3) Intermediate care facility/developmentally disabled.
> (4) Intermediate care facility/developmentally disabled habilitative.
> (5) Intermediate care facility/developmentally disabled-nursing.
> (6) Congregate living health facility.
> (7) Nursing facility.
> (8) Intermediate care facility/developmentally disabled-continuous nursing.

CAL. HEALTH & SAFETY CODE § 1418 (West 2011).

46. LEW ET AL., *supra* note 1, at 5.

47. *Id.*

discuss, this reporting system is ineffective.[48]

A. *Nursing Homes*[49]

Nursing homes, or skilled nursing facilities, are defined as health facilities that provide "skilled nursing care on an extended basis."[50] California Health and Safety Code section 1250(c) defines a nursing home as a place that provides continuous skilled and supportive care on an extended basis.[51] The elderly in nursing homes are an extremely vulnerable group, as they need assistance for virtually everything: food, medicine, shelter, and the most basic living necessities.[52] Care is typically "comprise[d] [of twenty-four] hour inpatient treatment, including physician care, skilled nursing, dietary, pharmaceutical, and activity services."[53]

The California nursing home population has remained relatively constant for the past ten years;[54] however, elder abuse remains a serious threat to the general elderly population. The Crime and Violence Prevention Center of the

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48. *See generally infra* Part II.

49. This Comment focuses on nursing homes, however, it is worth noting residential care facilities, which are briefly mentioned in this Comment. Residential care facilities parallel the structure of and possess the same issues faced by nursing homes. They range in size from six beds or less to over 100 beds and are also known as assisted living facilities, retirement homes, or board and care homes. *Residential Care Facilities for the Elderly (RCFE)*, CAL. DEP'T OF SOC. SERVS., http://www.ccld.ca.gov/PG543.htm (last visited June 21, 2011). The California Health and Safety Code defines an RCFE as:

> [A] housing arrangement chosen voluntarily by persons [sixty] years of age or over, or their authorized representative, where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided, based upon their varying needs, as determined in order to be admitted and to remain in the facility. Persons under [sixty] years of age with compatible needs may be allowed to be admitted or retained in a residential care facility for the elderly . . . .

HEALTH & SAFETY § 1569.2(l).

50. Richard S. Balisok et al., CONTINUING EDUCATION OF THE BAR, CALIFORNIA ELDER LAW LITIGATION: AN ADVOCATE'S GUIDE 3 (2011) [hereinafter CEB GUIDE].

51. HEALTH & SAFETY § 1250(c).

52. CEB GUIDE, *supra* note 50, at 3.

53. BAASS, *supra* note 30, at 5.

54. *Id.* ("This lack of nursing home growth reflects the increasing preference for alternatives to facility-based care and the growth in the number of assisted living facilities (assisted living facilities offer help with daily living activities, such as eating, bathing, and dressing, but generally do not provide intensive medical care).") *Id.* (footnote omitted).

California Attorney General's Office estimated that one in every twenty elders is a victim of elder abuse or neglect.[55] Further, thirteen percent of ombudsmen[56] complaints in California involve abuse, gross neglect, or exploitation compared to five percent for the rest of the country.[57]

Underreporting by nursing homes contributes to the continued abuse of our elderly. The prevalence of underreporting is caused by victims' inabilities to report assaults because of physical or mental incapacities; victims' fears of retaliation if they report; victims' lack of visitors to detect any wrongdoing; negligent facility operators that ignore reporting responsibilities; and a cultivated culture of silence amongst facility employees.[58]

Understaffing is also a major contributing factor to abuse in nursing homes. A facility must employ sufficient nursing staff to provide a minimum daily average of 3.2 nursing hours per patient day;[59] however, the California Office of Attorney General reported that over two out of three inspected nursing homes violated this requirement in 2004.[60] Without a healthy working environment, there can be little improvement in the quality of care in nursing homes.

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55. CEB GUIDE, *supra* note 50, at 6.
56. *See infra* Part I.B.1.
57. HILL, *supra* note 22, at 6.
58. BROKEN, *supra* note 36, at 2.
59. *See* CAL. HEALTH & SAFETY CODE §§ 1276.5, 1276.65, 1276.7, 1276.9 (West 2008 & Supp. 2011).
60. BROKEN, *supra* note 36, at 3.

B. *The Agencies*[61]

1. *The Ombudsman Program*

In 1972, the Federal Administration on Aging began the Ombudsman Program, which today exists in all states under the authorization of the Older Americans Act[62]—signed by President Lyndon Johnson in 1965.[63] "Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time state ombudsman."[64] "Thousands of local ombudsman staff and volunteers work in hundreds of communities throughout the nation as part of the statewide ombudsman programs, assisting residents and their families . . . ."[65]

In 1979, the State Older Californians Act, in conjunction with the Federal Older Americans Act, established the California Ombudsman Program within the California Department of Aging (CDA).[66] "Its mission is to advocate for

61. Practitioners will notice Adult Protective Service (APS)—which plays an important role as it relates to reporting requirements for elder abuse *outside* nursing homes—has been omitted from this section. Every California County has an APS agency to assist elder and dependent adults who are victims of abuse, neglect, or exploitation. *Adult Protective Services (APS)*, CAL. DEP'T OF SOC. SERVS., http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm (last visited Dec. 15, 2010). Where the CDPH investigates abuse cases by staff members of facilities, APS investigates reports of abuse in private homes and hotels or hospitals when the abuser is not a staff member. *Id.* For this reason, they do not have a role in dealing directly with nursing homes. *Id.* APS is, however, a part of the mandated reporting statute and attempts to increase public awareness of elder abuse. *Id.* APS also provides information and referrals to other agencies and educates the public about reporting requirements. *Id.*

62. *Elder Rights Protection*, DEP'T OF HEALTH & HUMAN SERVS. ADMIN. ON AGING, http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/index.aspx#purpose (last visited August 7, 2011). "The [Older Americans Act] set out specific objectives for maintaining the dignity and welfare of older individuals and created the primary vehicle for organizing, coordinating and providing community-based services and opportunities for older Americans and their families." *Older Americans Act and Aging Network*, DEP'T OF HEALTH & HUMAN SERVS. ADMIN. ON AGING, http://www.aoa.gov/AoARoot/AoA_Programs/OAA/index.aspx (last visited August 7, 2011).

63. *Older Americans Act and Aging Network*, *supra* note 62.

64. *Elder Rights Protection*, *supra* note 62.

65. *Id.*

66. HILL, *supra* note 22, at 4; LEW ET AL., *supra* note 1, at 7. The CDA "administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the [s]tate." *About the California Department of Aging (CDA)*, CAL. DEP'T OF AGING, http://www.aging.ca.gov/aboutcda/aboutcda.asp (last visited August, 7, 2011). It also "administers funds allocated under the federal Older Americans Act, the

the dignity, quality of life, and quality of care for all residents in long[-]term care facilities."[67] The California State Ombudsman, appointed by the CDA director, oversees thirty-five local programs (referred to as ombudsmen programs) comprised of paid staff, run by either a local Area Agency on Aging or a contracted private organization.[68] The paid staff at these thirty-five local programs in turn oversees a network of volunteers.[69] The Federal Administration on Aging's long-standing policy posits that ombudsmen "serve as advocates for residents of long-term care facilities" and resolve quality of care issues involving elders.[70] In addition to oversight of the local programs, the Office of the State Long-Term Care Ombudsman also develops policy.[71]

Trained community volunteers working under professional supervision usually serve as local ombudsmen.[72] They assist with questions or complaints "involving quality of care, residents' rights, fees, food or special diets, medication, activity programs, and community resources."[73] Ombudsmen have the right to enter facilities to hear, investigate, and resolve residents' complaints at any time the State Ombudsman considers reasonable and necessary.[74]

In California, ombudsmen have the additional task of receiving and verifying complaints of abuse and neglect.[75] California Welfare and Institutions Code section 15600(i) provides "that . . . local long-term care ombudsman programs . . . shall receive referrals or complaints . . . from any other source having reasonable cause to know that the welfare of an elder . . . is endangered."[76] Consequently, ombudsmen serve as the eyes and ears of California's long-term care facilities and "provide the first line of defense against elder abuse and

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Older Californians Act, and through the Medi-Cal program." *Id.*

67. LEW ET AL., *supra* note 1, at 7.

68. HILL, *supra* note 22, at 4–5.

69. *Id.* at 18.

70. LEW ET AL., *supra* note 1, at 7; 42 U.S.C. § 3058g(a)(3) (2006).

71. Jody L. Spiegel, *Residential Care Facilities for the Elderly California, in* ELDER LAW LITIGATION: AN ADVOCATE'S GUIDE 322 (Janette Tom ed., 2011).

72. *Id.*

73. *Id.*

74. Mello-Granlund Older Californians Act, CAL. WELF. & INST. CODE § 9722(a) (West 2010).

75. LEW ET AL., *supra* note 1, at 7.

76. Elder Abuse and Dependent Adult Civil Protection Act, CAL. WELF. & INST. § 15600(i) (West 2011).

exploitation."[77]

As official recipients and investigators of abuse and neglect complaints,[78] ombudsmen, with resident consent, *may* forward *any* mandated reporter complaints and their own investigation reports to local law enforcement, district attorneys, the CDPH, or the BMFEA.[79] However, where complaints involve *conduct amounting to physical abuse or criminal activity*, state law *requires* that the district attorney and the BMFEA are notified.[80] Given their extensive and important responsibilities, local ombudsmen play an integral role in nursing home regulations and the eradication of elder abuse.

2. Law Enforcement and District Attorneys

Law enforcement and district attorneys have the ability to hold perpetrators accountable for abuse in nursing homes. If reported conduct involves criminal activity, mandated reporters must immediately send reports to law enforcement.[81] In their capacity as criminal investigators and protectors of peace, officers have great potential to impact the investigation of elder abuse as a crime. They bring a level of expertise, authority, and impartiality to investigations that may not be achieved by local ombudsmen or CDPH surveyors.[82] However, reports are often untimely and, as a result, evidence becomes lost or indication of abuse fades, eliminating any chance of a successful criminal investigation.[83] Therefore, law enforcement has not played a very large role, thus far, in fighting elder abuse in nursing homes.

District attorneys also have the potential to help eliminate elder abuse but have not yet realized this role. To comply with the law, police officers must forward all timely reports of elder abuse to the local district attorney's office.[84] Despite this requirement, prosecutors rarely receive abuse reports; and, when they do, many believe they are too difficult

77. HILL, *supra* note 22, at 1.
78. WELF. & INST. § 15630; HILL, *supra* note 22, at 27.
79. *See* HILL, *supra* note 22, at 12–14.
80. LEW ET AL., *supra* note 1, at 8.
81. WELF. & INST. § 15630(c)(5); LEW ET AL., *supra* note 1, at 10.
82. LEW ET AL., *supra* note 1, at 10.
83. *Id.* at 8.
84. WELF. & INST. § 15630(b)(1)(A)(v).

to prosecute.[85] Several factors contribute to the passive approach to these cases: insufficient physician experts in geriatrics and abuse, lack of knowledge and training, limited availability of services for victims, misunderstanding and apathy, and poor coordination across agencies.[86] These factors combine to create a lack of faith in prosecutors' abilities to combat elder abuse crime.[87]

While law enforcement and district attorneys have the capacity to contribute to the eradication of elder abuse, institutional drawbacks and timeliness continue to pose threshold obstacles to criminal prosecution of elder abuse activity.

3. *Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA)*

The BMFEA, a division within the State Department of Justice, investigates and prosecutes nursing home fraud, abuse, and neglect through its own prosecutors, special agents, and forensic auditors.[88] The BMFEA may bring charges against a perpetrator or facility, may refer cases to or assist the local district attorney in prosecuting a case, or prosecute cases in lieu of or when the district attorney declines to prosecute.[89] The Violent Crimes Unit investigates and prosecutes physical elder abuse in nursing homes including crimes such as homicide, rape, false imprisonment, and assault and battery.[90] On the other hand, the Facilities Enforcement Team investigates and prosecutes the corporate entity, such as a nursing home, hospital, or residential care facility, for policies or practices leading to neglect or inadequate care.[91] The BMFEA is also required to provide training to local law enforcement in investigating and prosecuting elder abuse crimes and to the CDPH and local ombudsmen in evaluating and documenting elder abuse.[92]

The ombudsman or local law enforcement must notify the district attorney when cases involve criminal activity;

85. LEW ET AL., *supra* note 1, at 21.
86. *Id.*
87. *Id.*
88. *Id.* at 11.
89. *Id.*
90. BUREAU, *supra* note 44.
91. *Id.*
92. LEW ET AL., *supra* note 1, at 11.

however, it would be in the best interests of abused elders to also notify the BMFEA.[93] In reality, as with law enforcement and district attorneys, few referrals ever make it to the BMFEA.[94] The holes in the reporting system make it nearly impossible for any outside agency to effectively address elder abuse in nursing homes.

4. California Department of Public Health (CDPH)

Nursing homes may receive funding from the Federal Medicare or Medicaid programs or both.[95] For this reason, the federal and state governments share the responsibility of overseeing nursing homes,[96] and California facilities must generally comply with both sets of laws.[97] While California state law addresses the availability of services and equipment in a facility, federal law focuses on the care provided to individual residents.[98] Federal statutory requirements designate the Centers for Medicare & Medicaid Services (CMS), a federal agency, to define quality standards that nursing homes must meet to receive Medicare or Medicaid funding and to contract with state survey agencies to annually assess whether homes meet those standards.[99]

At the state level, the CDPH ensures and promotes a high standard of care in nursing homes throughout California.[100] Under state law, the CDPH must survey a nursing home at least once every two years and, under federal law, at least once every fifteen months.[101] The CDPH may also conduct a survey in response to complaints filed against a nursing home.[102] Unless it is an initial survey, nursing homes are not provided advance notice of a survey,

93. CAL. WELF. & INST. CODE § 15630(b)(1)(A)(iv) (West 2011).
94. LEW ET AL., *supra* note 1, at 11.
95. *See* CAL. HEALTH & SAFETY CODE § 1250(k) (West Supp. 2011).
96. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-517, NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES 6 (2008) [hereinafter GAO], *available at* http://www.gao.gov/new.items/d08517.pdf.
97. Russell S. Balisok, *Understanding Actions Against Skilled Nursing Facilities, in* ELDER LAW LITIGATION: AN ADVOCATE'S GUIDE 30 (Janette Tom ed., 2010).
98. *Id.*
99. GAO, *supra* note 96, at 6.
100. BAASS, *supra* note 30, at 9.
101. *Id.*
102. *Id.*

ensuring a candid view of how the facility operates on a daily basis.[103]

The Licensing and Certification Division of CDPH has about 1000 employees, more than 500 of whom are nurse surveyors who conduct approximately 1350 on-site inspections of nursing homes annually.[104] Each year, they respond to about 5000 complaints and 5300 events reported by facilities.[105] However, although CMS issues extensive guidance to states on determining compliance with federal quality requirements, the United States General Accounting Office found that some state surveys still understate quality problems at nursing homes.[106] California's state survey is one of them.[107]

C. Civil Statute: Elder Abuse and Dependent Adult Civil Protection Act (Elder Abuse Act / Mandated Reporting Act)

The Elder Abuse[108] and Dependent Adult[109] Civil Protection Act, codified in California's Welfare and

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103. *Id.* at 9–10.
104. *Id.* at 11.
105. *Id.*
106. GAO, *supra* note 96, at 6.
107. *Id.* at 2 n.3.
108. Section 15610.07 defines elder abuse as:

> "Abuse of an elder or a dependent adult" means either of the following:
>
> (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.
>
> (b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

CAL. WELF. & INST. CODE § 15610.07 (West 2011).

109. Section 15610.23 defines "dependent adults" as:

> (a) "Dependent adult" means any person between the ages of [eighteen] and [sixty-four] years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.
>
> (b) "Dependent adult" includes any person between the ages of [eighteen] and [sixty-four] years who is admitted as an inpatient to a [twenty-four] hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

WELF. & INST. § 15610.23.

The concern surrounding abuse of dependent adults also exists where the Mandated Reporting Act applies directly to dependent adults and the language is just as strong. For the purposes of this Comment, I focus primarily on elder abuse.

Institutions Code,[110] mirrors the model for child abuse by mandating health care providers to report suspected elder abuse and immunizing mandated reporters from civil liability.[111] The Act protects a "particularly vulnerable portion of the population from gross mistreatment in the form of abuse and custodial neglect."[112] It provides special remedies in order to grant extra protection to the elderly population from mistreatment by abuse or neglect, allowing personal representatives or successors to recover pain and suffering damages for elderly patients.[113]

The Act defines physical abuse by listing crimes identified in the corresponding Penal Code provision, further underscoring that all the acts of elder physical abuse have the potential for criminal prosecution.[114] The crimes listed include: assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint, sexual assaults and its various forms, lewd conduct, sexual penetration, and inappropriate use of physical or chemical restraint or psychotropic medication.[115] The Act also provides for enhanced or additional remedies for causes of action that involve physical abuse or neglect, abduction, or financial abuse of elders.[116] In addition to compensatory damages and all other remedies provided by law, remedies under the Act include postmortem recovery for pain and suffering and mandatory attorney fees and costs, including fees for the services of a conservator litigating an elder abuse claim.[117]

The Mandated Reporting Act is a provision within the Elder Abuse and Dependent Adult Civil Protection Act and codified in California Welfare and Institutions Code section 15630.[118] Enacted in 1982, the Mandated Reporting Act establishes requirements and procedures for mandatory and non-mandatory reporting to local agencies specializing in

110. WELF. & INST. §§ 15600–15675.
111. Easton v. Sutter Coast Hosp., 80 Cal. App. 4th 485, 491 (2000).
112. Benun v. Superior Court, 123 Cal. App. 4th 113, 123 (2004) (quoting Delaney v. Baker, 20 Cal. 4th 23 (1999)).
113. *In re* Conservatorship of Kayle, 134 Cal. App. 4th 1, 5–6 (2005).
114. LEW ET AL., *supra* note 1, at 9; WELF. & INST. § 15610.63.
115. WELF. & INST. § 15610.63.
116. *See id.* §§ 15657–15657.5.
117. *Id.*
118. *Id.* § 15630.

elder abuse, and also addresses local agency investigation and criminal prosecution of such cases.[119] It requires *any person* who has full or intermittent responsibility of an elder to immediately report any possible incidents that reasonably appear to be physical abuse[120] and outlines the system for reporting and investigating allegations of elder abuse.[121] If the abuse occurs in a nursing home, "the report shall be made to the local ombudsperson *or* the local law enforcement agency."[122] The ombudsman or local law enforcement *shall* then immediately report the case to the CDPH.[123] If criminal activity is suspected, ombudsman or local law enforcement must report to the BMFEA, and if physical abuse is suspected, they must report to the local district attorney.[124] The lengthy statute continues to outline more requirements and processes for mandated reporters.[125] Lastly, the statute makes failure to report physical abuse, as defined by the state, a misdemeanor.[126]

Since its 1991 enactment, the Act "has become the cornerstone of most actions on behalf of elders."[127] Plaintiff attorneys have become increasingly interested in elder abuse actions against nursing homes for physical abuse.[128] The Act itself "enable[s] interested persons to engage attorneys to take up the cause of abused elderly persons" by allowing plaintiffs to recover attorney fees and costs[129] for acts beyond "simple professional negligence."[130] Courts may award plaintiffs reasonable attorney's fees and costs; including, but not limited to, reasonable fees for conservator services

119. Covenant Care, Inc. v. Superior Court, 32 Cal. 4th 771, 779 (2004).

120. WELF. & INST. § 15630(a)–(b)(1). The statute also requires reporting of abandonment, abduction, isolation, financial abuse, or neglect. *Id.*

121. WELF. & INST. § 15630(b); LEW ET AL., *supra* note 1, at 6. "Any person" includes administrators, supervisors, licensed facility staff, elder care custodians, health practitioners, clergy members, and local law enforcement employees. WELF. & INST. § 15630(a). "Any person" does not supersede the attorney-client privilege. *Id.* § 15637.

122. WELF. & INST. § 15630(b)(1)(A) (emphasis added).

123. *Id.*

124. *Id.* § 15630(b)(1)(A), (iv)–(v).

125. *See id.* § 15630.

126. *Id.* § 15630(h).

127. CEB GUIDE, *supra* note 50, at 3.

128. *Id.*

129. Covenant Care, Inc. v. Superior Court, 32 Cal. 4th 771, 779 (2004).

130. *Id.* at 781.

devoted to litigation of the claim.[131]

California Health and Safety Code section 1430(b) serves as another civil legal remedy for nursing home residents and provides a right of action for abused residents.[132] However, few residents file suit under this section due to a $500 limit on civil damages.[133] If the legislature raised the limit on damages to $5000, it would strengthen nursing home residents' rights and ability to seek justice.[134] Residents may also have a civil action under the criminal statute following criminal prosecution. The California Supreme Court has held that "a civil action lies for a crime victim when the plaintiff is in the category of persons intended to be protected by the criminal statute."[135]

D. Criminal Statute: California Penal Code section 368

California Penal Code section 368 was enacted "to protect the members of a vulnerable class from abusive situations" where serious injury or death is likely to occur by imposing criminal liability for elder abuse.[136] The California legislature, in enacting the statute, declared that "infirm elderly persons . . . are a disadvantaged class, . . . cases of abuse of these persons are seldom prosecuted as criminal matters, and few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits."[137] By codifying these legislative findings, the California legislature recognized the importance of elder abuse criminal prosecution and provided law enforcement and district attorneys with the means necessary to prosecute abusive conduct.

Under section 368, it is a felony to willfully cause or permit infliction of physical pain or mental suffering on elders under circumstances or conditions likely to produce great

131. WELF. & INST. § 15657.

132. BROKEN, *supra* note 36, at 7.

133. *Id.*

134. *Id.* at 8.

135. Kathryn Stebner & Peter G. Lomhoff, *Practice and Procedures in Actions Against Residential Care Facilities for the Elderly, in* CALIFORNIA ELDER LAW LITIGATION: AN ADVOCATE'S GUIDE 393 (Janette Tom ed., 2010) (citing Angie M. v. Superior Court, 37 Cal. App. 4th 1217 (1995)).

136. Guardian North Bay, Inc. v. Superior Court, 94 Cal. App. 4th 963, 977 (2001) (quoting People v. Heitzman, 9 Cal. 4th 189, 203 (1994)).

137. Covenant Care, Inc. v. Superior Court, 32 Cal. 4th 771, 784 (2004).

bodily harm or death, or to have custody of an elder and willfully cause or permit the elder to be placed in a situation that endangers their health.[138] The imposed felony criminal liability may be applied to a wide range of abusive situations, including both active, assaultive conduct, as well as passive forms of abuse, such as extreme neglect.[139]

Penalties under the statute include one year in county jail and a $6000 fine or state prison for two to four years.[140] If the victim actually suffers great bodily injury[141] and is under seventy, the penalty is three years in state prison; if the victim is seventy or older, it increases to five years.[142] If the victim dies, the penalty is five or seven years in state prison.[143] Defendants who cause or permit infliction of physical pain or mental suffering under circumstances *not* likely to produce great bodily harm or death or in situations that *may* endanger elders could instead be charged with a misdemeanor under the same statute.[144] It is important to note that most physical abuse of elders constitutes a criminal offense on its own and may be prosecuted under other sections of the Penal Code not specified for elder abuse.[145]

II. ANALYSIS OF AGENCY EFFICACY AND NECESSARY PROPOSALS FOR PROGRESS

A. The Ombudsman Program

It is undoubted that local ombudsmen play a crucial role in the regulation of nursing homes and elder abuse. However, "[t]he ability of ombudsmen to perform their duties has been severely compromised in recent years due to state budget cuts. Many local ombudsman programs have been forced to reduce staff, hours, and services."[146] The resulting absence of ombudsmen in nursing homes has impacted communication and further insulated any abuse issues that

138. CAL. PENAL CODE § 368(b)(1) (West 2010).
139. People v. Heitzman, 9 Cal. 4th 189, 197 (1994).
140. PENAL § 368(b)(1).
141. "Great bodily injury" means a significant or substantial physical injury as defined in section 12022.7 of the California Penal Code. PENAL § 12022.7.
142. PENAL § 368(b)(2).
143. *Id.* § 368(b)(3).
144. *Id.* § 368(c).
145. LEW ET AL., *supra* note 1, at 9.
146. Spiegel, *supra* note 71, at 323.

occur. Without the ombudsmen, mandated reporters do not receive the education they need. Mandated reporters need regular training to remain up-to-date with changes in the law and understand the procedural requirements for reporting abuse.[147] Without this knowledge, reporting becomes an option rather than a requirement.

A recent California Senate investigation exposed flaws in the state's detection and response system that masked abuse cases.[148] In the past year, California's roughly 1000 ombudsmen made few reports to outside agencies with the power to prosecute abusers or their nursing homes.[149] Many abuse citations were actually triggered by public complaints rather than by nursing home facility reports.[150]

It is no coincidence that the number of these reports has declined along with the budget cuts. The cuts, among other things, have forced the state to stray from the original intent of making ombudsmen advocates for elders in nursing homes.[151] Ombudsmen cannot advocate for a population they do not have the resources to visit. The state must restore more of the ombudsman program budget to increase effective elder advocacy.

Conflicting federal and state laws for the ombudsman program have also been detrimental to elder abuse reporting. In the 1980s, the California Legislature passed the Elder Abuse Act requiring nursing home workers to report abuse and neglect to ombudsmen.[152] The law deemed ombudsmen the exclusive recipients and investigators of mandated abuse reports, who could then refer all cases to law enforcement and licensing agencies.[153] However, this conflicts with federal law.[154] The Federal Older Americans Act does not require the ombudsmen to receive or investigate complaints and requires written consent of a resident before an ombudsman can disclose abuse to other agencies.[155] Since states must meet requirements of the Older Americans Act for federal funding,

147. NDAA POLICY, *supra* note 20, at 16.
148. HILL, *supra* note 22, at 1.
149. *Id.*
150. BROKEN, *supra* note 36, at 2.
151. HILL, *supra* note 22, at 1.
152. *Id.* at 1, 12; *see also supra* Part I.C.
153. HILL, *supra* note 22, at 12–15.
154. *Id.* at 12.
155. *Id.* 12–15.

this inconsistency may have forced ombudsmen to drop serious abuse cases for lack of victim consent.[156] Only twenty-five percent of residents give consent to ombudsmen to release full reports to outside agencies.[157] Ombudsmen have noted significant challenges in obtaining resident consent, primarily stemming from capacity issues and retaliation fears.[158]

Residents have many reasons for denying consent, if they have the capacity to consent at all.[159] Many may fear retribution, threats, or simply want to avoid any more potential harm given the history of ineffective abuse investigation.[160] It is possible many do not even know to whom to report.

The California Ombudsman Program needs reexamination on a fundamental level. The core advocacy element from the Older Americans Act—addressing complaints and improving facility care and quality of life[161]—is lost in California ombudsmen's futile efforts to investigate abuse and neglect.[162] "California is one of the few states that relies on ombudsmen to investigate elder abuse and neglect."[163] Most states designate other agencies, not bound by the Older Americans Act's confidentiality provisions, to investigate nursing home abuse.[164] If California insists on keeping investigative duties with the ombudsmen, facilities should be required to ask residents to sign a consent form upon their initial admission to the facility allowing future investigation of abuse complaints as opposed to seeking consent after an allegation is made.[165]

Allowing mandated reporters to choose to whom to report

156. *Id.* at 8, 12.
157. *Id.* at 7.
158. LEW ET AL., *supra* note 1, at 9.
159. *Id.*
160. *Id.*
161. *See* HILL, *supra* note 22, at 1.
162. *See id.* at 15.
163. *Id.*; *see also supra* Part I.B.1.
164. HILL, *supra* note 22, at 15. "The only other states that require ombudsmen to investigate abuse and neglect are Alaska, South Carolina, New Jersey, and South Dakota . . . ." *Id.* New Jersey ombudsmen investigate abuse and neglect but have a more effective, centralized state program; all investigations are run from the state office by a team of registered nurses and law enforcement officers. *Id.* at 15–16.
165. *See id.* at 16 (following New Jersey model).

also creates a roadblock for successful criminal prosecutions of elder abuse. Given the option, reports overwhelmingly went to the ombudsmen rather than to law enforcement.[166] Facility administrators prefer to report to ombudsmen to limit the facility's criminal liability and because they are more familiar with the ombudsmen.[167] This creates a system where abuse is treated as an administrative, rather than criminal, matter.[168]

In 2008, the California Legislature considered requiring mandated reporters to forward instances of abuse to both the ombudsmen *and* local police.[169] This change would have sent reports to an agency not bound by the federal confidentiality requirement and potentially ignited increased prosecution of elder abuse. The nursing home industry, not surprisingly, opposed the bill and it died in committee.[170] Another bill requiring ombudsmen to report cases of abuse and neglect to district attorneys, however, did pass and went into effect in 2009.[171] Unfortunately, it still conflicts with the federal consent requirement and few reports have been made to prosecutors.[172]

Mandatory reporting to actors beyond the ombudsmen (e.g. law enforcement) is imperative and efforts to amend the statute to require this additional reporting should continue.[173] The mandated reporting laws should also be amended to add a time period requirement, to specify the manner of reporting, and to add penalties for non-reporting or failure to do so within the designated time period.[174] A time period and specified manner of reporting would help minimize the impact a delayed investigation has on critical evidence.[175]

166. LEW ET AL., *supra* note 1, at 19.
167. *Id.*
168. *Id.*
169. HILL, *supra* note 22, at 13.
170. *Id.*
171. *Id.* at 14.
172. *Id.*
173. *See* NDAA POLICY, *supra* note 20, at 18.
174. *Id.*
175. *Id.*

B. Law Enforcement and District Attorneys

As discussed above, law enforcement and district attorneys rarely prosecute elder abuse cases due to problems of proof, court delays, and the lack of incentives to prosecute these suits.[176] The very nature of working with the infirm or elderly brings many challenges. Elders' complex needs and characteristics vary greatly from other victims of abuse.[177] Their impairments and disabilities may interfere with their ability to report a crime; recognize the abuse they have suffered; remember details of the event (especially due to any cognitive impairments from a stroke or dementia); or effectively testify in court (a speech disability may render a victim incapable of communicating).[178] Even more difficulties arise where elders require specialized medical equipment, medication, have hearing and vision impairments, or fatigue easily.[179] The elders' individual fears, embarrassment, vulnerability, and reluctances to come forward must also be taken into account.[180] These factors and special needs make it difficult for untrained officers or prosecutors to even recognize nursing home abuse has occurred, let alone effectively prosecute it.[181]

"The uniqueness and the special needs of the elder victim require that certain changes occur within both the rules of evidence and trial procedure in order to effectively prosecute these matters."[182] Procedural requirements often present a roadblock to effective prosecution of elder abuse offenses. Because of memory loss, illness and, in many cases, death, expedited processes are necessary.[183] The time lapse between the investigation of the alleged abuse and the actual trial present further evidentiary and trial procedure challenges.[184] For example, the victim may have initially been competent and able to testify but then fell ill, or in many cases even died, before the opportunity to appear before the court.[185] In

176. CAL. WELF. & INST. CODE § 15600(h) (West 2011).
177. NDAA POLICY, *supra* note 20, at 9.
178. *Id.*
179. *Id.*
180. *Id.*
181. *See id.*
182. *Id.* at 18.
183. *Id.* at 10–11.
184. *Id.* at 18–19.
185. *See id.* at 19.

this scenario, adopting an elder hearsay exception would significantly enhance the abilities of prosecutors to bring elder abuse charges.[186]

The United States Supreme Court case *Crawford v. Washington*[187] also acts as an evidentiary roadblock to criminal prosecution of elder abuse where it significantly limits the admission of hearsay evidence.[188] The *Crawford* court held that it was unconstitutional to introduce videotaped or prerecorded statements of victims and witnesses in criminal proceedings because it denied defendants the right to confront their accuser.[189] This makes it challenging to prosecute abuse in cases where the victim is no longer available to testify due to incapacity or death.[190] Without this medium of testimony, criminal prosecutions of elder abuse will continue to fail. For this reason, courts should give priority to cases involving elder abuse. Additionally, an alleged elder abuse perpetrator's history of abuse, often utilized in the domestic violence context, should be admissible as evidence of a propensity for committing elder abuse.[191] Without these changes in court procedure and evidentiary rules, numerous elder abuse crimes may go unpunished for sheer procedural rather than substantive issues.

A lack of training and expertise in prosecuting abuse cases also contributes to the lack of successful elder abuse prosecutions.[192] The BMFEA is required to provide training to local law enforcement, prosecutors, and ombudsmen; however, the BMFEA has not offered these trainings since 2008.[193] As a result, there is a lack of general knowledge regarding investigating and prosecuting crimes against elders amongst the very agencies designated to protect elders.[194]

Elder abuse cases often involve victims just as traumatized and fragile as those in child abuse and domestic

186. *Id.*
187. Crawford v. Washington, 541 U.S. 36 (2004).
188. LEW ET AL., *supra* note 1, at 19–20.
189. *Id.* at 20.
190. *See id.*
191. NDAA POLICY, *supra* note 20, at 19.
192. LEW ET AL., *supra* note 1, at 33.
193. *Id.*
194. *See id.*

violence cases.[195] More elder victims may be willing to come forward and proceed with a criminal trial if closed circuit television or video testimonial were allowed.[196] This would reduce the stress on the victims and account for diminished capacity.[197] These improvements would give law enforcement and district attorneys the tools needed to effectively prosecute these atrocious crimes and create criminal accountability in nursing homes.

C. Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA)

The Mandated Reporting Act[198] requires the ombudsman or local law enforcement officer to notify the BMFEA of all cases involving criminal activity.[199] However, the BMFEA typically receives referrals from the CDPH.[200] In a recent reporting quarter, CDPH reported eighty-three abuse and neglect referrals to the BMFEA while ombudsmen reported only fourteen.[201] This is troubling because the CDPH typically only refers citation reports to the BMFEA after an entire investigation and citation review are completed.[202] These referrals may be months old by the time they reach the BMFEA.[203] Regardless of this delayed reporting, from 2000 to 2010, the number of BMFEA criminal filings has been as high as 136 annually and as low as seventy-five with the number of convictions ranging from forty-three to eighty-nine.[204] However, coinciding with Governor Schwarzenegger's budget cuts to the ombudsman program, the filings and convictions from 2008 to 2010 dropped from eighty-nine to seventy-seven per year and sixty-one to forty-six, respectively.[205]

These statistics should be much higher given the prevalence of elder abuse. An estimated one in every twenty

195. NDAA POLICY, *supra* note 20, at 19.
196. *Id.*
197. *Id.*
198. *See supra* Part I.C.
199. LEW ET AL., *supra* note 1, at 11.
200. *Id.*
201. *Id.* at 11–12.
202. *Id.* at 12.
203. *Id.*
204. BUREAU, *supra* note 44.
205. *Id.*

elders is abused[206] and over 100,000 residents live in California nursing homes.[207] Following this logic, it is possible that over 5000 elders are abused annually. At a minimum, the CDPH should refer cases to the BMFEA upon the initial filed complaint rather than after a complete investigation and review.[208]

While the BMFEA efforts are limited by the few referrals they receive, they also have the ability to fight elder abuse through mandated training programs.[209] The BMFEA developed a mandatory training video on mandated reporting requirements for all nursing home staff.[210] While certainly a valiant effort, the purpose of these training videos may be thwarted by facilities that are relied upon to show the video. Facility administrators have the opportunity to instruct staff to the contrary and posit themselves as the first notification to insulate their liability.[211] In determining whether an incident is reportable, facilities effectively filter the reported information and instill a culture of responding to serious criminal abuse as administrative concerns.[212] Without more effective programming and education from the BMFEA, it is unlikely this culture will change. The BMFEA must uphold the integrity of the Mandated Reporter Act by finding methods to directly train the mandated reporters. This may encourage more nursing home staff who witness abuse to come forward.

D. California Department of Public Health (CDPH)

The CDPH is the state's only consumer protection agency for nursing home residents, but it has done little to insulate nursing home residents from abuse and neglect.[213] Nursing home complaints increased by eleven percent (approximately 500 complaints) from 2003 to 2005, yet, during that same time, the hours CDPH spent on investigating complaints decreased by more than 28,000 hours.[214] CDPH

206. CEB GUIDE, *supra* note 50, at 6.
207. BAASS, *supra* note 30, at 3.
208. LEW ET AL., *supra* note 1, at 12.
209. *See id.* at 11.
210. *Id.* at 30.
211. *Id.*
212. *Id.*
213. BROKEN, *supra* note 36, at 5.
214. *Id.*

substantiated only about one in four complaints;[215] most likely because the average on-site investigation length took only 4.1 hours, under half the national average of 9.29 hours per investigation.[216] CDPH also cut their nursing home inspections teams by thirty percent and studies by the United States Government Accountability Office consistently found California inspectors understated harm to residents and failed to detect serious deficiencies.[217] Complaint investigations also do not comply with California law requiring investigations within twenty-four hours for imminent danger cases and within ten working days for all other cases.[218] Instead, some occur at the next regular inspection, which can be up to fifteen months later; once staff has moved on, evidence is lost, and witnesses are unavailable.[219] CDPH must take accountability for its poor investigating and citing, and raise standards to at least that of the national average. Despite budget cuts, CDPH must not take shortcuts in investigating and surveying nursing homes where some of our most vulnerable population resides.

CDPH's inherently administrative role also does not recognize the severity of elder abuse crimes and addresses most cases as licensing issues. Federal CMS comparative surveys show that state survey agencies miss serious deficiencies or understate their scope and severity, typically involving quality of care shortcomings.[220] The true extent of understatement may be modest, though, since CMS does not require regional offices to federally track when state surveyors cite low scope and severity and regional offices do not enter data timely or consistently.[221] Deficient CDPH surveys will typically result in the issuance of a "Statement of

215. *Id.*

216. *Id.*

217. *Id.* The Budget and Accounting Act of 1921 established the United States Government Accountability Office. *GAO: Working for Good Government Since 1921*, U.S. GOV'T ACCOUNTABILITY OFFICE, http://www.gao.gov/about/history/articles/working-for-good-government/01-introduction.html (last visited Sept. 21, 2011). It serves as the investigative arm of Congress and examines all subjects related to the receipt and disbursement of public funds. GAO, *supra* note 96, at 52.

218. BROKEN, *supra* note 36, at 6.

219. *Id.*

220. GAO, *supra* note 96, at 11–19, 27.

221. *Id.* at 27–28.

Deficiency and Plan of Correction" or a citation.[222] The statement simply lists the violations by state or federal regulation and the conduct found; it is discharged when the facility administrator fills in the form with the facility's plan of correction.[223] Thus, nursing homes easily write off deficiencies on an administrative form or pay them off as a citation fine; further contributing to the culture of treating criminal elder abuse as a simple, correctable defect.[224] The Mandated Reporter Act should require CDPH to report any suspected physical abuse and neglect to law enforcement upon initial complaint so that criminal conduct is accountable to criminal authorities.

Despite the California legislature's efforts to combat elder abuse through minimum staffing requirements, mandated reporting, and enhanced trainings requirements, the CDPH declared that its primary purpose was to ensure federal standards were met, and not to enforce state laws, which exceed federal standards.[225] This begs the question of whose job it is to enforce the state laws. CDPH should be required immediately to investigate backlogged complaints, comply with state timing requirements for investigations, conduct more thorough investigations, and evaluate compliance with California nursing home laws.[226] No other agency has the capacity to survey nursing homes to ensure state standards are met.

III. ADDITIONAL PROPOSALS: IMPROVEMENTS BEYOND THE AGENCIES

The improvements of the agencies and systems already in place, outlined in Part IV of this Comment, are crucial steps towards eradicating elder abuse, however, there are additional enhancements that can be made to protect the elderly population. The regulations in place could be developed more fully. Regulatory standards and public awareness could be raised. Lastly, an increase in funding, while not crucial to some of the proposals, would undoubtedly facilitate further action in deterring elder abuse.

222. Balisok, *supra* note 97, at 40.
223. *Id.*
224. *See* LEW ET AL., *supra* note 1, at 30
225. BROKEN, *supra* note 36, at 5–6.
226. *Id.* at 8.

A. Litigation as a Deterrent

While there have been attempts to fight elder abuse with slow-moving legislation, tort law has become more responsive to the needs of elders in danger.[227] Litigation should be a strong deterrent to elder abuse, instead, the high burden of proof deters litigation. "[I]n order to obtain the [heightened] remedies available under [Elder Abuse and Dependent Adults Civil Protection Act], a plaintiff must demonstrate by clear and convincing evidence that the defendant is guilty of something more than [simple professional] negligence; [the plaintiff] must show reckless, oppressive, fraudulent, or malicious conduct."[228] The Act's goal was to provide remedies for "acts of egregious abuse" against elders.[229] Although the Act may be a valuable remedy, only a handful of elder abuse victims are able to find justice and compensation due to the high burden of proof.[230] While the Act provides some accountability, it leaves room for improvement.[231] The California Legislature should consider lowering the burden to "preponderance of the evidence."[232] This would greatly improve access to the civil justice system, and attorneys may be more willing to accept elder abuse cases.

B. Enforcing Timely Reporting

The Mandated Reporting Act requires reporters to "report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days."[233] Nursing homes, however, often do not follow this time requirement, blatantly ignoring the law. "Nursing home staff often report an abuse incident internally up the chain of command within the facility rather than simultaneously reporting to outside investigators."[234] The internal investigation or allegation verification delays reporting to the appropriate state agencies

227. *See* Williams, *supra* note 7, at 868.
228. Smith v. Ben Bennett, Inc., 133 Cal. App. 4th 1507, 1518–19 (2005) (quoting Delaney v. Baker, 20 Cal. App. 4th 23, 31 (1999)).
229. *Id.* at 1519.
230. BROKEN, *supra* note 36, at 7.
231. *Id.*
232. *Id.* at 8.
233. CAL. WELF. & INST. CODE § 15630(b)(1) (West 2011).
234. LEW ET AL., *supra* note 1, at 30.

and negatively impacts any outside investigation.[235] The delay destroys any attempts at criminal prosecution because evidence of injuries fade, witnesses might leave or be convinced not to come forward, perpetrators may move on to different facilities, victims may no longer remember pertinent details, and the abuse remains undetected.[236] Further, the internal investigation may be the end of the line for many reported incidents, depending on the outcome of the investigation; leaving a dead end for many potential victims.[237] The previously mentioned BMFEA training programs could positively impact nursing homes and potentially negate this tendency.[238]

A delay in reporting greatly hinders effective elder abuse investigation and prosecution. On the occasion state agencies are properly notified, it is often untimely and rarely by the mandated reporter with direct knowledge. Rather, CNAs report to administrators who only report the conduct to outside agencies following an internal investigation,[239] in violation of the Mandated Reporting Act requirement of *immediate* reporting by the mandated reporter.[240] Administrators do not have direct experience with the alleged abuse and have an interest in minimizing the severity of the incident as an employee of the facility.[241] They may misconstrue facts or be reluctant to reveal critical details to protect the nursing home from liability.[242]

District attorneys should be encouraged to prosecute mandated reporters who fail to comply with their statutory duties.[243] Between 1993 and 2004, district attorneys prosecuted only forty-six cases for the failure to comply with the Mandated Reporting Act.[244] Prosecutors are often reluctant to charge mandated reporters because many times reporters are the only witnesses to the abuse and will not

235. *Id.*

236. BROKEN, *supra* note 36, at 6; *see* LEW ET AL., *supra* note 1, at 8, 29, 38; *see* NDAA POLICY, *supra* note 20, at 9.

237. LEW ET AL., *supra* note 1, at 30.

238. *See supra* Part II.C.

239. LEW ET AL., *supra* note 1, at 30.

240. CAL. WELF. & INST. CODE § 15630(b)(1)(A) (West 2011); LEW ET AL., *supra* note 1, at 30.

241. LEW ET AL., *supra* note 1, at 30.

242. *Id.*

243. *Id.* at 37.

244. *Id.*

testify to their failure to report the abuse in a timely manner.[245] Regardless, prosecutors should hold mandated reporters accountable,[246] particularly in cases where the failure causes an investigatory delay and an ultimate inability to prosecute. Researchers contend that the delay or failure to report may be a greater offense than the abuse itself because withholding a report involves premeditation or "a degree of conscious effort," whereas abuse often occurs in the heat of the moment.[247] This proactive approach is necessary to preserve the integrity of the Mandated Reporter Act and the possibility of successful elder abuse convictions.

C. Establishing a Staff-to-Resident Ratio Requirement

An established staff-to-resident ratio requirement would be a significant step towards the eradication of elder abuse in nursing homes. In 2002, a congressional study, based on eight years of research, "recommended 4.1 nursing hours of care per resident day" (NHPRD).[248] California currently has a minimum staffing level requirement of 3.2 NHPRD, which allows nursing homes to easily schedule staff for business hours, but tends to leave night shifts understaffed.[249]

In 2001, the California Legislature passed Assembly Bill 1075, requiring the CDPH to establish a staff-to-resident ratio by 2003; however, this two-year deadline was not met.[250] A consumer advocate organization then filed suit against the CDPH.[251] The case resulted in a court order to complete the staff-to-resident regulation to go into effect in 2007.[252] Two years past the deadline in 2009, the regulations went into effect but were not operational because of a lack of appropriation of funds.[253] CDPH stipulated that $208 million would be necessary to implement the regulations annually and neither the Governor nor the Legislature requested an appropriation for this regulation,[254] leaving an uncertain

245. *Id.* at 38.
246. *Id.*
247. *Id.*
248. BROKEN, *supra* note 36, at 3.
249. BAASS, *supra* note 30, at 15.
250. *Id.*
251. *Id.*
252. *Id.*
253. *Id.*
254. *Id.*

future for a state staff-to-resident ratio requirement. Successful implementation of such a requirement would greatly improve the quality of care in nursing homes. Abuse thrives in nursing homes where understaffing, the stressful nature of the work, and long hours can take a toll on staff members.[255]

D. Tracking Abusive Nursing Home Employees

A state or federal tracking system would help eliminate the criminal cycle of abuse in nursing homes by keeping abusive CNAs from being rehired at a different nursing home. Criminals convicted of crimes such as rape, elder abuse and assault with a deadly weapon work with our elders every day.[256] State data shows that at least 210 workers and applicants are unsuitable to work in nursing homes, but are nonetheless scheduled to resume or begin employment.[257] In early 2010, a judge also interpreted the rules of the government's home health aide program to permit felons to work as aides; "only a history of specific types of child abuse, elder abuse or defrauding of public assistance programs" disqualifies a person from working in a nursing home.[258] But even perpetrators who committed those crimes are not always properly screened.[259] When a staff member is terminated without a criminal record for elder abuse, they may simply move on to the next facility.[260] Without a system in place to track these offenders, the cycle of abuse continues.

Nursing homes currently require staff members to submit to a fingerprint background check before being hired,[261] but without criminal convictions, this prerequisite is

255. LEW ET AL., *supra* note 1, at 16; Sengstock, *supra* note 14, at 45–46.

256. Evan Halper, *California has Paid Scores of Criminals to Care for Residents*, L.A. TIMES (Sept. 24, 2010), http://articles.latimes.com/2010/sep/24/local/la-me-homecare-20100924.

257. *Id.*

258. *Id.*

259. *See id.*

260. *See* LEW ET AL., *supra* note 1, at 38 ("Currently, care staff are required to clear a fingerprint background check before being hired or as a term of continued employment. This system matches an applicant's fingerprints with criminal conviction records. Therefore, a background checking system that relies on criminal conviction means that many prospective employers will not discover an applicant's history of abuse unless the applicant was criminally convicted.").

261. *Id.*

meaningless. California should, instead, adopt a reporting and tracking system of nursing care staff with allegations of elder abuse that have been substantiated by the ombudsmen, CDPH, BMFEA, or other agency regardless of a criminal conviction.[262]

The CDPH currently maintains an online database of CNA certification statuses (which may be revoked for abuse); however, it requires the CNA certification number and is not searchable by name only.[263] Certification numbers are not available to the public, out-of-state employers, or employers hiring employees in a non-CNA capacity.[264] A centralized database, searchable by all prospective employers, where former employers may report staff terminated because of a substantiated claim of abuse, would be an ideal way to track staff with a history of elder abuse.[265] The system could also include an appeal process to ensure that staff members are provided a due process hearing to challenge the entry of their names into the database.[266] Broadening the background checks to include allegations of abuse and increasing the search capabilities of the CNA certification online database would help eliminate the rehiring of abusive employees and foreclose the nursing home cycle of abuse.

E. Implications of the Elder Justice Act

President Obama enacted and signed the Elder Justice Act (EJA) in early 2010 as part of the Health Care Reform Bill.[267] The EJA is the first comprehensive national legislation enacted on elder abuse.[268] It authorizes an Elder Justice Coordinating Council to make coordination recommendations for federal, state, local, and private agencies related to elder abuse; allocates funding to Adult Protective Services; creates state grants to test different elder abuse detection and prevention methods; establishes centers to develop elder abuse forensic expertise; provides financial

262. *Id.*
263. *Id.*
264. *Id.* at 38–39.
265. *Id.* at 38.
266. *Id.*
267. Lori A. Stiegel, *Elder Justice Act Becomes Law, but Victory is Only Partial*, 31 BIFOCAL 72, 73 (2010).
268. *Id.*

support to the Long-Term Care Ombudsman and training programs; and enhances care staffing with incentives.[269]

However, there is great skepticism as to the actual impact the EJA will have in eliminating elder abuse. First, no funding has been appropriated to support the EJA provisions.[270] Second, the EJA excluded justice-related provisions, part of the original EJA bill introduced in 2002, which recognized the important role of criminal and civil litigation.[271] Congress must continue efforts to obtain appropriations for the EJA provisions in order for the EJA to have its intended effects.

The Elder Abuse Victims Act of 2009 (EAVA) contained the justice-related provisions excluded from the EJA and recognized the required involvement and intervention of criminal and civil justice systems to meet the needs of elder abuse victims.[272] Passed by the House of Representatives in 2009, the EAVA awaited its fate before the Senate.[273] Among other things, the EAVA would have required the U.S. Attorney General to evaluate state laws protecting elders from abuse, neglect, and exploitation and established a plan for elder justice programs and activities throughout the country.[274] It would have funded the creation of the "Center for the Prosecution of Elder Abuse, Neglect, and Exploitation" and either elder justice prosecution positions or positions to coordinate elder justice-related cases.[275] The EAVA would also have funded elder abuse investigation training for law enforcement officials.[276] If the Senate passed this bill and it received the requisite funding, this would have significantly impacted the elder abuse landscape and provided much needed attention to a growing national problem. The EAVA was read and referred to the Committee on the Judiciary in February 2009 and never passed during the 111th

269. *Id.*
270. *Id.*
271. *Id.*
272. *Id.*
273. *Id.*
274. Press Release, Congressman Joe Sestak, House Passes Elder Abuse Victims Act (Apr. 27, 2009) (on file with author), *available at* 2009 WLNR 7921000.
275. *Id.*
276. *Id.*

Congress.[277] Therefore, unless it is reintroduced, the EAVA only stands for what could have been.

F. Promoting Public Awareness

Increased public awareness of the atrocities of elder abuse may inspire more action by politicians and prosecutors. The media often reports on the most egregious offenses. The *Los Angeles Times* recently published an article on the successful conviction of an employee at an upscale retirement home.[278] The employee often laughed while viciously attacking residents with body-slams and other methods of physical abuse.[279] The article noted how particularly shocking this case was because it occurred in an *elite* retirement home where residents pay upwards of $70,000 a year.[280]

While that case certainly deserved attention, awareness should also be given to the less egregious but equally offensive cases that occur more frequently and out of the spotlight. Education on the prevalence of elder abuse, the warning signs, the steps to take if an individual suspects elder abuse, and how individuals can aid in abuse prevention should be readily available to the public. The California Advocates for Nursing Home Reform (CANHR)—a nonprofit advocacy organization dedicated to improving the choices, care, and quality of life for California's long term care consumers—established a strong foundation for positive advocacy efforts on behalf of the elderly community.[281] Further, the Elder Abuse Task Force of Santa Clara County, created in 1981, promotes education of and advocates for the prevention of elder and dependent adult abuse amongst professionals working with the elderly and the general

277. H.R. 448, 111th Cong. (as referred to Comm. on the Judiciary, Feb. 12, 2009).

278. Robert Faturechi, *Retirement home worker convicted of torture, elder abuse,* L.A. TIMES (Apr. 9, 2010), http://articles.latimes.com/2010/apr/09/local/la-me-elder-abuse9-2010apr09.

279. *Id.*

280. *Id.*

281. *About CANHR, supra* note 18. Since 1983, CANHR's goal has been to educate and support long term care consumers and advocates regarding legal rights and remedies and to create a united voice for long term care reform and humane alternatives to institutionalization through direct advocacy, community education, legislation and litigation. *Id.*

community.[282] However, their efforts must be buttressed by collaboration with other agencies.

This increased awareness should also extend to the criminal realm for investigative and prosecutorial purposes. It is important for prosecutors to at least receive training in the identification, investigation, and prosecution of elder abuse and neglect.[283] Without widespread dissemination of education on the recognition of this problem, there is no catalyst for necessary and overdue reform.

G. Prioritizing Elder Abuse in the Court System: Elder Abuse Prosecution Units and Specialty Courts

The criminal justice system recognized that "child abuse and domestic violence can be curbed by the enactment of new laws and the use of special procedures," including hearsay exceptions and specialized courts.[284] The system should also be "amenable to change on behalf of our growing elder population."[285] While the tools to prosecute elder abuse are in existence, elder abuse prosecution is not very common. In 2001, only forty-one percent of prosecutors surveyed nationally had handled elder abuse cases.[286] The rate of crime against elders will inevitably rise along with the nation's growing elderly population.[287] "Prosecutors should

282. Telephone Interview with Cynthia Thorp, Co-Chairperson, Elder Abuse Task Force of Santa Clara County (June 12, 2011). The Elder Abuse Task Force (EATF) has held professional conferences with national experts, promoted legislation and funding for programs to assist vulnerable elders, and provided training for law enforcement agencies as well as community education on this important topic. *Id.* The EATF developed a twenty-page training manual, ELDER ABUSE TASK FORCE OF SANTA CLARA COUNTY, ELDER ABUSE—GUIDELINES FOR PROFESSIONAL ASSESSMENT AND REPORTING 1 (4th ed. 2008), which covers elder and dependent adult abuse identification, assessment, reporting, prevention, and resources for further assistance. *Id.* They also produced an elder abuse training DVD/video for professionals—DVD: 2008 The Silent Cry: Elder Abuse Assessment and Reporting (ELDER ABUSE TASK FORCE OF SANTA CLARA COUNTY 2008)—designed to help professionals better understand and identify elder and dependent adult abuse and comply with the California elder and dependent adult abuse mandatory reporting laws. *Id.* To obtain any of the above training materials, request a speaker, or receive more information, the Elder Abuse Task Force of Santa Clara County may be contacted at ElderAbuseTaskForce@hotmail.com. *Id.*

283. NDAA POLICY, *supra* note 20, at 5.

284. *Id.* at 1.

285. *Id.*

286. *Id.* at 2.

287. *Id.*

be aware of this increase and the impact that it will have on their communities and their resources."[288] The National District Attorneys Association (NDAA) adopted a policy in 2003 to set this tone.[289] The NDAA "recognize[d] that elder abuse is a serious crime and public health issue with far reaching consequences for both the victims and society. The [NDAA] endorse[d] the vigorous prosecution of cases of elder abuse, neglect, and financial exploitation."[290]

The current understanding of and efforts to combat elder abuse is similar to the understanding of child abuse and domestic violence twenty years ago.[291] Intervention in the related areas of domestic violence developed slowly at first, "hampered by a lack of research findings on causes and limited funding directives;" it was the advocacy of concerned practitioners and survivors that gained the attention of the public and the recognition from researchers and professionals.[292] The creation of special elder abuse prosecution units, modeled after the systems implemented in juvenile dependency and domestic violence courts more prevalent today, would help bring about more elder abuse convictions. The NDAA "endorses . . . the creation of special elder abuse units within the prosecutor's office or the designation of a specially trained prosecutor to handle elder abuse cases."[293] Elder abuse cases involve complexities that

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288. *Id.*

289. *See id.* at 1.

290. *See id.*

291. David A. Wolfe, *Elder Abuse Intervention: Lessons from Child Abuse and Domestic Violence Initiatives, in* ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 501, 501–02 (Richard J. Bonnie & Robert B. Wallace eds., 2003) ("Efforts to understand and deal with abuse of the elderly by family members or other caregivers are reminiscent of where the study of child abuse and woman abuse was [twenty] years ago . . . . The common denominator for this discussion is that all three populations involve close, interdependent relationships with others, which form the potential circumstances and context for abuse. At the same time, there are many important differences between the contexts and consequences of elder abuse when compared to other abused populations, and these differences have important implications for how one might intervene with the elderly. Nonetheless, lessons derived from progress in child abuse and domestic violence initiatives provide a valid starting point for drawing more attention to elder abuse.").

292. *Id.* ("Society's responses to woman abuse and child abuse, in particular, took more than two decades to turn from preliminary recognition and acknowledgment to more uniform opposition and action.").

293. NDAA POLICY, *supra* note 20, at 5.

make successful prosecution difficult, just as in child abuse and domestic violence cases.[294] "[T]here is still much to be done in terms of detection and investigation" in the two related fields of child abuse and domestic violence, but the "knowledge gained from past and recent efforts" in the areas may benefit current elder abuse intervention planning.[295]

"[O]fficials and scholars theorize that frustration with the adversary system has . . . led to the proliferation of specialty courts."[296] As such, the creation of Elder Abuse Courts may be the impetus needed to help eliminate elder abuse from nursing homes. Elder Abuse Courts would improve the probability of criminal elder abuse convictions and serve as an effective deterrent to abusive nursing home staff who believe they can escape liability due to the insulate nature of nursing homes and the vulnerable characteristics of impaired elders.[297] The increased convictions would also allow efficient tracking of convicted elder abusers and prevent them from obtaining positions at different nursing homes, in or out of state.[298] Finally, the Elder Abuse Courts may increase the general population's awareness of elder abuse where increased attention of law enforcement and district attorneys will likely result in increased media coverage and education.

The Bay Area's own Contra Costa County is pioneering this effort in California, and serves as a mentor court for counties inside and outside the state.[299] Every Tuesday

294. *Id.*

295. Wolfe, *supra* note 291, at 501.

296. Tamar M. Meekins, *"Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of A New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 13 (2006)

297. *See* LEW ET AL., *supra* note 1, at 39 ("Consolidating all dependent adult or elder abuse and neglect matters into one courtroom enables the judge and other court personnel to develop expertise in the special issues unique to adults with disabilities. These courts often establish expedited processes for moving cases, become familiar with the accommodations this population may require, and develop partnerships with community and social service agencies that can provide advocacy and other victim witness assistance.").

298. *See supra* Part III.D. The current background checking system relies on criminal convictions; meaning prospective employers will not discover an applicant's history of abuse unless the applicant was criminally convicted. LEW ET AL., *supra* note 1, at 38.

299. Nick Casper, *The Elder Court: Interview with Judge Joyce Cram*, CONTRA COSTA LAWYER, March 2011, at 12, 14, *available at* http://www.cccba.org/attorney/pdf/cclawyer/2011-03.pdf. Since its inception, many counties have approached Contra Costa about its Elder Court. *Id.* As a mentor court, part of its mandate is to let other court systems know about Elder

morning, Judge Joyce Cram presides over an Elder Court calendar dedicated to every possible elder-related case; whether they involve crimes, conservatorships, financial abuse, physical abuse, civil disputes, restraining orders, or small claims.[300] Judges in other departments who find an elder component after an initial review may transfer the elder related case to Judge Cram's courtroom.[301] District attorneys may file criminal cases directly.[302] The court also offers a variety of unique services for elders.[303]

The efforts of the Contra Costa Elder Court reflect an awareness of the acute needs of the elderly population and provide a strong model for other counties to model. The creation of an Elder Court does not necessarily require additional funding.[304] Counties should seriously consider reallocating resources to an Elder Court to protect an abused and vulnerable population. Contra Costa County provides one template for an Elder Court; however, any interest in creating some variant of an elder court would be a significant step towards eradicating elder abuse.

H. Increasing Funding

Lastly, funding remains a crucial element to eliminating elder abuse. Funding is needed to address the complex elder forensic issues that arise in elder abuse cases that are specific and require medical professionals, including, but not limited to: interpreting medical records, assisting in filing decisions, appearing as experts in trials, and conducting training on medical issues.[305] System-wide improvements require adequate funding.

Court and what it entails. *Id.* The Contra Costa Elder Court has attended roundtables in both Northern and Southern California; will be flying to Buffalo and Erie County, New York to set up an Elder Court; and will meet with a Judge from Chicago to discuss establishing a whole Elder Division. *Id.*

300. *Id.* at 13.

301. *Id.*

302. *Id.*

303. *See id.* The Contra Costa Elder Court involves Senior Peer Counselors from County Health Services in assisting elders before hearings and created a Senior Help Center to advise self-represented seniors. *Id.* See Tina Olton, *Senior Peer Counseling – Elder Court Support Program*, CONTRA COSTA LAWYER, March 2011, at 24–25, *available at* http://www.cccba.org/attorney/pdf/cclawyer/2011-03.pdf, for more information about these resources.

304. *Id.* at 14.

305. *See* NDAA POLICY, *supra* note 20, at 9.

The ombudsman program, in particular, relies on state and federal funding; however, budget cuts have greatly impacted local programs.[306] In 2008, Governor Schwarzenegger cut the program's budget in half.[307] Following this, ombudsman reporting significantly fell: including a forty-one percent drop to the state licenser of nursing homes and a twenty-nine percent drop to the State Attorney General's Office.[308] As a result, mandated reporters do not make reports as often because they know the ombudsman cannot visit as frequently.[309] The cuts also increased reliance on volunteers for abuse and neglect investigations.[310] This is problematic because these volunteers may not have the expertise and reliability necessary for successful results.[311]

In a half step forward, Governor Schwarzenegger signed a bill restoring $1.6 million to the ombudsman program's annual budget in August 2009.[312] However, this is nearly twenty-seven percent below that of the 2007–08 budget.[313]

CONCLUSION

Despite a strong presence in the public eye, progress in the areas of research, causes, consequences, and interventions of elder abuse is noticeably absent; resulting in apathy and a lack of intervention initiatives.[314] Nursing homes pose a unique threat to the health and safety of the abused elderly population.[315] Victims are often silent and vulnerable while perpetrators are often over-worked and rarely held accountable for abuse.[316] There are federal and state systems in place to combat this life-threatening trend, but inherent flaws and a lack of funding thwart any significant efforts.[317] As the general and elderly population

306. HILL, *supra* note 22, at 5–6.
307. *Id.* at 5.
308. *Id.* at 6. Research has shown that the presence of ombudsmen increases abuse reporting. *Id.* at 23.
309. *Id.* at 21.
310. *See id.* at 18.
311. *See id.* at 19.
312. *Id.* at 5.
313. *Id.*
314. Wolfe, *supra*, note 291, at 501.
315. *See supra* Part I
316. *See supra* Part II.
317. *See supra* Part II.

continues to grow, more must be done to ensure the protection and safety of this vulnerable group.[318]

Although research on elder abuse has been limited, evidence suggests that it is as widespread as child abuse.[319] Elderly living in nursing homes are at particular risk for abuse and neglect because most suffer from several chronic diseases that lead to physical and cognitive functioning limitations and dependency.[320] The most rapidly growing segment of the population is the elderly and "the proportion of persons estimated at risk for nursing home use at some time in their lives" will likely increase over time.[321] Thus, while only about 100,000 elders living in a California nursing home on any given day may be at risk for abuse, over their collective lives many more are at risk during any period of nursing home use.[322]

This Comment sought to present current data on a startlingly at-risk population, outline those involved with a statutory or regulatory duty, and present possible solutions to improve the system in place. It introduced many of the key players involved, including agencies that must be able to work in conjunction with another for effective change to be made. Any attempts to eliminate elder abuse in nursing homes require open communication and sharing of resources.[323] The ultimate goal of this Comment was to bring attention to an area that is in dire need of advocacy. Unlike child abuse, the elder abuse advocacy community is not as vociferous. Victims are much closer to the end of their lives and survivors typically are not able to raise awareness after experiencing such an ordeal. Until institutional improvements are implemented and an effective elder abuse reporting system is in place, the elderly population will not have a voice or be treated with the dignity they deserve.

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318. *See supra* Part III.

319. Catherine Hawes, *Elder Abuse in Residential Long-Term Care Settings: What is Known and What Information is Needed?, in* ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 446, 446 (Richard J. Bonnie & Robert B. Wallace eds., 2003).

320. *Id.*

321. *Id.* at 447.

322. *Id.*

323. *See* NDAA POLICY, *supra* note 20, at 15.

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